STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF MEDICAL EXAMINERS' POLYSOMNOGRAPHY PROFESSIONAL STANDARDS COMMITTEE

(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

www.tennessee.gov

APPLICATION INSTRUCTIONS FOR LICENSURE IN POLYSOMNOGRAPHY

Documents needed for licensure as a technologist

1. Completed and notarized application. Please be advised that all pages of the application must be returned.
2. Submit two (2) original letters of recommendation from health professionals on letterhead. The letters must be written within the last six months and contain original signatures.
3. Attachment 1 – Verification of Education
4. Attachment 2 - Clearance from other state Polysomnography Licensure Boards. (Required only if licensed in other states)
5. Attachment 3 – Verification of credentialing and exam scores.
6. Attachment 4 – Verification of supervising physician.
7. Fees - $200.00 plus $10.00 state regulatory fee. Total amount **$210.00.** All fees are non-refundable.
8. For initial licensure in Tennessee applicants must obtain a criminal background check. For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions.
9. Attachment 5 – Declaration of Citizenship

Documents needed for full license if practicing Polysomnography on July 1, 2007

1. Completed and notarized application. Please be advised that all pages of the application must be returned.
2. Submit two (2) original letters of recommendation from health professionals on letterhead. The letters must contain original signatures.
3. Attachment 2 - Clearance from other state Polysomnography Licensure Boards. (Required only if licensed in other states)
4. Attachment 3 – Verification of credentialing and exam scores.
5. Attachment 4 – Verification of supervising physician.
6. Fees - $200.00 plus $10.00 state regulatory fee. Total amount **$210.00.** All fees are non-refundable.
7. For initial licensure in Tennessee applicants must obtain a criminal background check. For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions.
8. Attachment 5 – Declaration of Citizenship

Documents needed for temporary licensure as a technician

1. Completed and notarized application. Please be advised that all pages of the application must be returned.
2. Submit two (2) original letters of recommendation from health professionals on letterhead. The letters must contain original signatures.
3. Attachment 1 – Verification of Education.
4. Attachment 2 - Clearance from other state Polysomnography Licensure Boards. (Required only if licensed in other states)
5. Attachment 4 – Verification of supervising physician.
6. Fees - $200.00 plus $10.00 state regulatory fee. Total amount **$210.00.** All fees are non-refundable.
7. For initial licensure in Tennessee applicants must obtain a criminal background check. For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions.
8. Attachment 5 – Declaration of Citizenship

Persons currently enrolled in a sleep study program

1. Please fill out "Letter of Notification" **only. Click Here** for document.

UNDERSTANDING THE APPLICATION PROCESS

1. **All application fees are non-refundable. Accordingly, please familiarize yourself with the laws, rules and requirements for licensure prior to submitting your application.**

2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

Tennessee Board of Medical Examiners'
Polysomnography Professional Standards Committee
665 Mainstream Drive
Nashville, TN 37243 (37228 for courier service only)

3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred. The Committee asks that you please give the Committee office every consideration in this matter.

4. If necessary documentation has not been received when your application has been received by the Committee office, an initial deficiency letter will be sent to you. The supporting documentation requested in the letter must be received in the Committee office ninety (90) days from the date of the initial deficiency letter. Files not completed within ninety (90) days will be closed.

5. Absent any complicating factors, the average application processing time is six (8) weeks. Once the application is completed, your file will be reviewed and an initial licensure determination made. You will be notified by letter of the initial determination. Application approval may also be accessed through our webpage at www.tennessee.gov/health and click on licensure verification.

6. If an address change occurs at any time during the application process, you must notify the Committee office, in writing, immediately.

7. You have the option to receive all correspondence from the Department of Health electronically. Should you "opt in", you will no longer receive physical mail from this office. Opting in does not discharge your obligation to provide the Department with a current physical address and email address. You are required by statute and rule to notify the Department of an address change within thirty (30) days of any such change.

8. It is strongly recommended that you do not make arrangements to accept employment as a Polysomnography Technologist in Tennessee until you are granted a license by the Board of Medical Examiners' Polysomnography Professional Standards Committee.

9. All documents which are provided to this office in conjunction with your request for a polysomnography license becomes part of the public record and must be released pursuant to a public records request.

7. All documents and fees required to be submitted by you or which must be requested from the appropriate institution in this application process, must be mailed directly to:

Tennessee Board of Medical Examiners'
Polysomnography Committee
665 Mainstream Drive
Nashville, TN 37243

For Federal Express or Special Courier:
Tennessee Board of Medical Examiners'
Polysomnography Committee
665 Mainstream Drive
Nashville, TN 37228

The application form is not acceptable if any portion of it or any other documents required to be submitted by the rules or the application itself has been executed and dated prior to one year before filing with the Committee.

IMPORTANT: After July 1, 2010 you must have either a Tennessee License or a Board issued authorization in your possession before you can lawfully practice.

Thank you for your cooperation. We will make every effort to process your application in an efficient manner.

For Official Use Only

3202-001	$200.00
3202-006	$ 10.00

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF MEDICAL EXAMINERS'
POLYSOMNOGRAPHY PROFESSIONAL STANDARDS COMMITTEE
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

www.tennessee.gov/health

APPLICATION FOR LICENSE AS A POLYSOMNOGRAPHIC TECHNOLOGIST/TECHNICIAN

READ INSTRUCTIONS PRIOR TO COMPLETING APPLICATION. APPLICANTS MUST COMPLY WITH ALL INSTRUCTIONS. FILL IN ALL BLANKS; IF NOT APPLICABLE, STATE N/A

Please indicate the type of license for which you are applying.

_____ Technologist
_____ Technician (Temporary License – **not for use if currently enrolled in sleep study program**)
_____ Grandfather TCA 63-31-106(c)

Name as it will appear on license:_____

(First) (Middle) (Last)

Have you been known by any other name? Y N If yes, list names: _____

_____

_____

Date of Birth: Mo. _____ Day _____ Yr. _____ Place of Birth _____

(City) *(State or Country)*

Social Security Number: _____-_____-_____ U.S. Citizen: Y N Sex: M F

Are you entitled to Live and Work in U.S.? Y N

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces or been released from active duty to a reserve component (If yes, please provide proof of same.) Y N

Are you the spouse of a member of the armed force4s who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component (If yes, please provide proof of same.) Y N

Present Mailing Address _____ Home Phone: (_____) _____- _____

_____

_____ Work Phone: (_____) _____- _____

Email address: _____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? Y N

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of this page if you need additional space. (SEND **ATTACHMENT #1** TO THE EDUCATIONAL INSTITUTION WHERE YOU COMPLETED YOUR PROGRAM)

From: ________ To: __________ ______________________________ ______________________________
Mo/Yr Mo/Yr Educational Institution Location

From: ________ To: __________ ______________________________ ______________________________
Mo/Yr Mo/Yr Educational Institution Location

From: ________ To: __________ ______________________________ ______________________________
Mo/Yr Mo/Yr Educational Institution Location

From: ________ To: __________ ______________________________ ______________________________
Mo/Yr Mo/Yr Educational Institution Location

Please complete your entire employment history starting with the most current position first. Use the back of this page if you need additional space.

DATES **LOCATION**

From: ________ To: __________ ______________________________ ______________________________
MM/YY MM/YY City/State Position/Duties
____

From: ________ To: __________ ______________________________ ______________________________
MM/YY MM/YY City/State Position/Duties
____

From: ________ To: __________ ______________________________ ______________________________
MM/YY MM/YY City/State Position/Duties
____

From: ________ To: __________ ______________________________ ______________________________
MM/YY MM/YY City/State Position/Duties
____

From: ________ To: __________ ______________________________ ______________________________
MM/YY MM/YY City/State Position/Duties
____

From: ________ To: __________ ______________________________ ______________________________
MM/YY MM/YY City/State Position/Duties
____

From: ________ To: __________ ______________________________ ______________________________
MM/YY MM/YY City/State Position/Duties

CERTIFICATION INFORMATION

	YES	NO
Are you or have you ever been licensed to practice polysomnograohy in another state?	_____	_____
Are you or have you ever been licensed in any other profession in Tennessee or another state?	_____	_____

List below **ALL** STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED as a polysomnographic technologist. Additional pages may be added if necessary. Submit a copy of **Attachment 2** to all such states, countries, or provinces regarding such licensure, certification, or permit.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

List below ALL states, countries, or provinces in which you hold or have ever held a license, certification, or permit as a health professional other than a polysomnographic technologist. Additional pages may be added if necessary. Submit a copy of **Attachment 2** to all such states, countries, or provinces regarding such licensure, certification, or permit.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "yes" to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. **IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION. Additional information may be requested and/or required before a licensure decision may be made.**

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate clinical diagnosis, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;

   b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

   c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction, and alcoholism.

3. **"Minor Traffic Offense"** generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under intoxication or reckless driving.

4. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

5. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

6. **"Illegal use of illicit or controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS	**Yes**	**No**
1. Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice?	____	____

[*If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.]*

COMPETENCY INFORMATION CONTINUED

QUESTIONS	Yes	No
2. Do you currently use any chemical substances which in any way impair of limit your ability to practice medicine with reasonable skill and safety?	____	____
If so, please list:_____		
3. At any time within the past two years, have you engaged in the illegal use of controlled substances?	____	____
4. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you do not consume alcohol and/or do not engage in the illegal use of controlled substances?	____	____
5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism or other diagnosis of a predatory nature?	____	____
6. If you have ever held or applied for a license or certificate to practice as a polysomnographer in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	____	____
7. Have ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	____	____
8. Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?	____	____
9. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic Violation that has not been expunged?	____	____
10. Have you ever been rejected or censured by a medical society?	____	____
11. In relation to the performance of your professional services in any profession:	____	____
a. Have you ever had a final judgment rendered against you;	____	____
b. Have you ever entered into any settlement of any legal action; or	____	____
c. Are there any legal actions pending against you or to which you are a party?		
12.. Have you ever held a license or certificate in any health care profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	____	____

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, of _____
(Applicant's Name) (City) (State)
being duly sworn and identified as the person referred to in this application, attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's website at http://share.tn.gov/sos/rules/0880/0880-02.20150426.pdf, and agree to abide by them in the practice of polysomnography in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Committee may find necessary, which may include a full Board interview.

RELEASE to the Committee, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice polysomnography.

AUTHORIZE the Committee, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications:

RELEASE from liability the Committee, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and other qualifications for certification.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing accurate and adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA-protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE **DATE**

ATTACHMENT 1

STATE OF TENNESSEE
DEPARTMENT OF HEALTH,
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF MEDICAL EXAMINERS'
POLYSOMNOGRAPHY PROFESSIONAL STANDARDS COMMITTEE
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

www.tennessee.gov/health

EDUCATION VERIFICATION

APPLICANT: Supply the information requested and then mail this entire form to the school at which you completed your training.

Please check one of the following:

_____ I graduated from a polysomnographic educational program that is accredited by the commission on accreditation of allied health education programs;

_____ I graduated from a respiratory care educational program that is accredited by the commission on accreditation of allied health education programs and completed the curriculum for a Polysomnography certificate established and accredited by the committee on accreditation for respiratory care of the commission on accreditation of the allied health education programs;

_____ I graduated from an electroneurodiagnostic technologist educational program with a polysomnographic technology track that is accredited by the commission on accreditation of allied health education programs; or,

_____ I successfully completed an accredited sleep technologist educational program (A-STEP) that is accredited by the American Academy of Sleep Medicine.

NOTE: Most schools require a fee, so you may want to contact the institution before mailing this form so that you can attach their fee.

Full Name: _____
(Last) (First) (Middle/Maiden)

Social Security Number: _____ - _____ - _____

Student Identification Number: _____

TO WHOM IT MAY CONCERN:

I am applying for a license to practice as a polysomnographer in the State of Tennessee. Please forward a certificate of completion, diploma or final official transcript along with this form to the Board of Medical Examiners' Polysomnography Professional Standards Committee, 665 Mainstream Drive, Nashville, TN 37243. (37228 for courier service only)

Thank you for your cooperation and prompt response.

_____ _____
Applicant's Signature **Date**

ATTACHMENT 2

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF MEDICAL EXAMINERS'
POLYSOMNOGRAPHY PROFESSIONAL STANDARDS COMMITTEE
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

www.tennessee.gov/health

VERIFICATION OF OTHER STATE LICENSE(S)

APPLICANT: Please provide the information requested in the top box and then mail one form to the licensure board in EACH state where you hold OR HAVE EVER HELD a license to practice any medical profession. (You may copy this form.) **NOTE:** Some states require a fee to process verification of licensure information.

_____ was granted a license to practice _____
(Name of Applicant) *(Profession)*
with license number _____ on _____ in the State of _____.
(Date)

The Tennessee Board of Medical Examiners requests that I submit evidence of the current status of my license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to:

State of Tennessee
Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243

Date: _____ _____
Applicant's Signature

_____
Applicant's typed or printed name

THIS PORTION IS TO BE COMPLETED BY THE ADMINISTRATIVE OFFICE OF THE STATE MEDICAL BOARD

Name in Full As it Appears on License: _____

License Number _____ Profession _____ Date Issued _____

Basis of issuance: _____ Endorsement/Reciprocity with _____
(Check One) (State)
_____ Written Examination _____
(Name of Exam)

The License is currently active and registered? Yes _____ No _____
Is there any derogatory information on file? Yes _____ No _____ If yes, an explanation must be attached.

_____ _____ _____
Authorized Signature Title Date

ATTACHMENT 3

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF MEDICAL EXAMINERS'
POLYSOMNOGRAPHY PROFESSIONAL STANDARDS COMMITTEE
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

www.tennessee.gov/health

BOARD OF REGISTERED POLYSOMNOGRAPHIC TECHNOLOGISTS VERIFICATION

Only if or when you are credentialed with the BRPT, please complete this form and mail it to the address below:

BOARD OF REGISTERED POLYSOMNOGRAPHIC TECHNOLOGISTS
Credentialing and Program Manager
8400 Westpark Drive, 2nd Floor
McLean, VA 22102

Website: www.brpt.org Phone: (703) 610-9020 Fax: (703) 610-0229

To Be Completed By Applicant (Please Print In Ink)

Dear BRPT Official:

I am applying for a license to practice as a Polysomnographer in the State of Tennessee. The State Board of Medical Examiners' Polysomnography Professional Standards Committee requires that a credential letter be **forwarded directly to their** office by the BRPT.

Applicants Name: _____
First Middle Last

Did you pass the national certifying exam? _____ Yes _____ No Credential #:_____

I do hereby authorize you to release the information requested to the Committee office.

_____ _____
Signature Date

PLEASE MAIL VERIFICATION DIRECTLY TO:

Board of Medical Examiners' Polysomnography Professional Standards Committee
665 Mainstream Drive
Nashville, Tennessee 37243

ATTACHMENT 4 **Applicant's Name:**_____

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF MEDICAL EXAMINERS'
POLYSOMNOGRAPHY PROFESSIONAL STANDARDS COMMITTEE
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

SUPERVISION NOTIFICATION

This section must be completed by the supervising physician.
(This page may be duplicated if necessary)

List all practice settings:

1) Setting:

_____
Supervisor's Signature

_____
Printed Name

_____
Practice Setting

_____
Tennessee License Number

2) Setting:

_____
Supervisor's Signature

_____
Printed Name

_____
Practice Setting

_____
Tennessee License Number

3) Setting:

_____
Supervisor's Signature

_____
Printed Name

_____
Practice Setting

_____
Tennessee License Number

4) Setting:

_____
Supervisor's Signature

_____
Printed Name

_____
Practice Setting

_____
Tennessee License Number

ATTACHMENT 5

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

Pursuant to T.C.A. § 4-58-101 et seq, the Eligibility Verification for Entitlements Act (also known as the "SAVE Act") requires the Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that *every adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) _____ _____.
Healthcare Profession (Please Print) **License number if applicable**

Please Print Legibly

1. Name:_____
Last First Middle Maiden_
2. Mailing Address: _____
_
3. Phone Number: Home: (____)_____-_____ Office: (____)_____-_____ Fax: (____)___-_____
4. I am a United States Citizen: ____Yes ____No
5. I am a foreign national not physically present in the United States _____Yes _____No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:

   a) Tennessee Driver's License, or photo ID issued by Department of Safety.
   b) A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Safety criteria.
   c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
   d) A federally issued birth certificate.
   e) A valid, unexpired U.S. passport.
   f) A report of birth abroad of a U.S. citizen.
   g) A certificate of citizenship.
   h) A certificate of naturalization.
   i) A U.S. citizen ID card.
   j) Any successor document to #'s a-i above.
   k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.

7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)

a) Permanent Residents
b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).
c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
d) Refugees who meet the qualifications set out in 8 U.S.C. 1157
e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status– "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this _____ day of _____, 20__.

_____
Signature

Sworn to before me this _____day of _____, 20__.

_____ AFFIX SEAL HERE
NOTARY PUBLIC

My Commission Expires:_____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.